

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27761

State File No.

FILED SEP 10 1941

Registration District No.

Primary Registration District No. 3004

Registrar's No. 57

1. PLACE OF DEATH:

(a) County Bates
(b) City or town Butler
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Butler Memorial Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution two days
(Specify whether
In this community 33 years
years, months, or days)

3. (a) PRINT
FULL NAMEAngeline E. Van Ben Thusen3. (b) If veteran,
name war.3. (c) Social Security
No. ✓4. Sex F5. Color or
race W6. (a) Single, widowed, married,
divorced M

6. (b) Name of husband or wife

L. H. Van Ben Thusen6. (c) Age of husband or wife if
alive 68 years

7. Birth date of deceased

April
(Month)6 1884
(Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

57418

hr. min.

9. Birthplace

Savannah

(City, town, or county)

S. D.

(State or foreign country)

10. Usual occupation

Housewife

11. Industry or business

12. Name John W. Fuller13. Birthplace SavannahIll.

(State or foreign country)

14. Maiden name Mary E. Bliss15. Birthplace SavannahIll.

(State or foreign country)

16. (a) Informant L. H. Van Ben Thusen(b) Address Adrian Mo.17. (a) Burial
(Burial, cremation, or removal)(b) Date thereof 8-25-41
(Month) (Day) (Year)(c) Place: burial or cremation Leveath & Son18. (a) Signature of funeral director Leveath & Son(b) Address Adrian19. (a) Aug 25-1941
(Date received local registrar)(b) Nina L. Culver
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bates
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 24
year 1941 hour 1 minute 50 A. M.21. I hereby certify that I attended the deceased from Aug 23, 1941, to Aug 24, 1941;
that I last saw her alive on Aug 24, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death

Acute
nephritis

Due to

Due to

Heart

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) 0
(b) Date of occurrence 0
(c) Where did injury occur? 0
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature Adrian (City or town)
Address Butler Mo Date signed 8-25-41

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 7,

District File Number 9-41-1618

Date Filed 9-9-41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.
working under my personal supervision.

Signed *Leah*

Licensed Embalmer No. 3650

P. O. Address Adrian Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27761
State File No. _____
Registrar's No. 57

Registration District No. 50

Primary Registration District No. 3004

1. PLACE OF DEATH:

- (a) County Bates
(b) City or town Butler
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Butler Memorial Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community 33 years years, months or days)

3. (a) PRINT FULL NAME Angeline E. Van Ben Husen
3. (b) If veteran, name war. _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced. m
6. (b) Name of husband or wife. _____ 6. (c) Age of husband or wife if alive. _____ years
7. Birth date of deceased. _____ (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____ (State or foreign country)

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

- (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) Oct 2, 1941 (b) Maria L. Culver
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County Bates
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 24 Year 1941 Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above.

- Immediate cause of death _____ Duration _____

- Due to _____
Due to _____

- Other conditions _____ (Include pregnancy within 3 months of death)

- Major findings: _____
Of operations _____

- Of autopsy _____

- Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) _____

- (b) Date of occurrence _____

- (c) Where did injury occur? _____ (City or town) (County) (State)

- (b) Did injury occur in or about home, on farm, in industrial place, in public place? _____

- While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature _____ (M. D. or other)

- Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

